

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington**

To: Resource Based Relative Value
Scale (RBRVS) Users:
Anesthesiologists
Advanced Registered Nurse
Practitioners
Ophthalmologists
Psychiatrists
Emergency Physicians
Nurse Anesthetists
Physicians
Physician Clinics
Registered Nurse First Assistants
Family Planning Clinics
Federally Qualified Health Centers
Health Departments
Laboratories
Managed Care Plans
Podiatrists
Radiologists
Regional Administrators
CSO Administrators

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For Information Call:
1-800-562-6188

Supersedes: 00-14 MAA
00-60 MAA
00-68 MAA
00-80 MAA
01-12 MAA

From: James C. Wilson, Assistant Secretary
Medical Assistance Administration (MAA)

**Subject: Update To Resource Based Relative Value Scale (RBRVS) &
Anesthesiology Relative Value Guide (RVG), Vendor Rate Increase
and Expedited Prior Authorization (EPA) Changes**

Effective with dates of service on or after July 1, 2001, the Medical Assistance Administration (MAA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2001 relative value units (RVUs);
- The updated Year 2001 Relative Value Guide base anesthesia units (BAUs);
- The updated Medicare Clinical Laboratory Fee Schedule (MCLFS);
- The Year 2001 additions of Current Procedural Terminology (CPT™) codes and Health Care Financing Administration Common Procedure Coding System (HCPCS) Level II codes;
- A legislatively appropriated two and one-tenth percent (2.1%) vendor rate increase;
- Updated Conversion Factors; and
- Technical changes.

Maximum Allowable Fees and Base Anesthesia Units (BAU)

In updating the fee schedule with Year 2001 RVUs, BAUs, and clinical laboratory fees, MAA maintained overall budget neutrality. The 2001-2003 Biennium Appropriations Act authorizes this two and one-tenth percent (2.1%) vendor rate increase for MAA fee-for-service programs. Conversion factors have been adjusted to reflect the changes listed on the preceding page.

Below are the updated conversion factors:

Title	Procedure Codes	Conversion Factor
Maternity	58611, 59000, 59025, 59400-59410, 59430, 59510-59525, 59610-59622, and 5930M-5959M	\$45.34
Children's Primary Health Care	99201-99215, 99431-99435, 99381-99395 and 0252M	36.52
Adult Primary Health Care	99201-99215	21.27
Anesthesia		15.49
All Other Procedures Codes	Except Clinical Laboratory	22.41

Technical Changes

I. Pain Management/Other Services

- MAA is adding the codes in the following table to the *Pain Management and Other Services* section of the Physician Related Services Billing Instructions. Those pain management and selected surgical services that are commonly performed by anesthesiologists and CRNAs are *not* paid with anesthesia base and time units. **Do not use anesthesia modifiers when billing for services payable only under RBRVS.**
- Two postoperative epidurals and two hospital follow-up calls are allowed for pain management. Only one (1) unit may be billed per epidural; this is billed as a procedure. Do NOT bill time. **Use modifier 59 to indicate epidurals for pain management.**

CPT Code	Short Description	CPT Code	Short Description
20600	Drain/inject, joint/bursa	64577	Implant neuroelectrodes
20605	Drain/inject, joint/bursa	64580	Implant neuroelectrodes
20610	Drain/inject, joint/bursa	64585	Revise/remove neuroelectrode
27096	Inject sacroiliac joint	64590	Implant neuroreceiver
61790	Treat trigeminal nerve	64595	Revise/remove neuroreceiver
62263	Lysis epidural adhesions	64626	Destr paravertbrl nerve c/t
62287	Percutaneous diskectomy	64627	Destr paravertbrl nerve add-on
63600	Remove spinal cord lesion	64802	Remove sympathetic nerves
64550	Apply neurostimulator	64804	Remove sympathetic nerves
64553	Implant neuroelectrodes	64809	Remove sympathetic nerves
64555	Implant neuroelectrodes	64818	Remove sympathetic nerves
64560	Implant neuroelectrodes	76000	Fluoroscope examination
64565	Implant neuroelectrodes	76003	Needle localization by x-ray
64573	Implant neuroelectrodes	76005	Fluoroguide for spine inject
64575	Implant neuroelectrodes	95970	Analyze neurostim, no prog

II. Digital Mammography

Effective with dates of service on or after July 1, 2001, MAA will pay for digital mammography using the following new 2001 HCPCS codes:

HCPCS Code	Description	Maximum Allowable Fee
G0202	Screening mammography producing direct digital image, bilateral, all views	\$77.51 \$31.93 -26 \$45.58 -TC
G0203	Screening mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views	\$66.67 \$21.33 -26 \$45.34 -TC
G0204	Diagnostic Mammography, direct digital image, bilateral, all views	\$77.51 \$31.93 -26 \$45.58 -TC
G0205	Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views	\$66.67 \$21.33 -26 \$45.34 -TC
G0206	Diagnostic Mammography, direct digital image, unilateral, all views	\$42.58 \$17.70 -26 \$24.88 -TC
G0207	Diagnostic Mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views	\$42.58 \$17.70 -26 \$24.88 -TC

III. PET Scans

- MAA covers Positron Emission Tomography (PET) scans only after prior authorization has been obtained. To request prior authorization send a written or fax request to:

Division of Health Services Quality Support
 Quality Fee-For-Service Section
 PO Box 45506
 Olympia, WA 98504-5506
 Fax (360) 586-2262

- The following CPT procedure codes for PET scans are covered after prior authorization has been obtained:

78608-78609, 78459, 78491-78492, and 78810

- The following new PET scan codes have been added effective July 1, 2001, and will be paid "By Report." In addition, HCFA has discontinued a number of current PET scan HCPCS codes listed in the 2001 HCPCS book, effective June 30, 2001. Replaced codes are noted.

HCPCS Code	Replaced HCPCS Code	Description
G0210		PET Imaging whole body; diagnosis; lung cancer, non-small cell
G0211	G0126	PET Imaging whole body; initial staging; lung cancer, non-small cell
G0212		PET Imaging whole body; initial staging; lung cancer; non-small cell
G0213		PET Imaging whole body; diagnosis; colorectal cancer
G0214		PET Imaging whole body; initial staging; colorectal cancer
G0215	G0163	PET Imaging whole body; restaging; colorectal cancer
G0216		PET Imaging whole body; diagnosis; melanoma
G0217		PET Imaging whole body; initial staging; melanoma
G0218	G0165	PET Imaging whole body; restaging; melanoma
G0219		PET Imaging whole body; melanoma for non-covered indications
G0220		PET Imaging whole body; diagnosis; lymphoma
G0221	G0164	PET Imaging whole body; initial staging; lymphoma
G0222	G0164	PET Imaging whole body; restaging; lymphoma
G0223		PET Imaging whole body or regional; diagnosis; head and neck cancer, excluding thyroid and CNS cancers

HCPCS Code	Replaced HCPCS Code	Description
G0224		PET Imaging whole body or regional; initial staging; head and neck cancer; excluding thyroid and CNS cancers
G0225		PET Imaging whole body or regional; restaging; head and neck cancer; excluding thyroid and CNS cancers
G0226		PET Imaging whole body; diagnosis; esophageal cancer
G0227		PET Imaging whole body; initial staging; esophageal cancer
G0228		PET Imaging whole body; restaging; esophageal cancer
G0229		PET Imaging; Metabolic brain imaging for pre-surgical evaluation of refractory seizures
G0230		PET Imaging; Metabolic assessment for myocardial viability following inconclusive SPECT study

- HCPCS codes **G0126**, **G0163**, **G0164** and **G0165** will be discontinued effective June 30, 2001.
- HCPCS code **G0125** has a definition change: “PET Imaging whole body or regional; single pulmonary nodule.”

IV. Osseointegrated Implants

Effective with dates of service on or after January 1, 2001:

- CPT codes 69714-69718 require prior authorization through the LE process (refer to page A5 of the Physician Related Services Billing Instructions).
- The procedure can be performed in an inpatient hospital setting or outpatient hospital setting.
- Hospitals must bill the appropriate DRG. The osseointegrated implant is included in the DRG.
- Outpatient hospitals must bill revenue code 278 and attach an invoice for the osseointegrated implant. Reimbursement is through a ratio of cost to charges (RCC).

V. Laboratory

The following state-unique code is added for the HIV Virtual Phenotype test and is paid “By Report”:

State-Unique Code	Description
8999M	Infectious agent virtual phenotype analysis, HIV 1

VI. Therapeutic or Diagnostic Injections

- **New Codes:** The following injections are paid at acquisition cost when provided in a physician's office. Q3013 must be billed in conjunction with CPT code 67221. Payment for IV infusion is bundled in 67221 and will not be paid separately.

HCPSC Code	Description	Diagnosis Restrictions
Q3013	Injection, verteporfin, 15 mg	Restricted to 362.52
K0548	Injection, insulin lispro, up to 50 units	None

- **Synvis/Hyalgan:** MAA is changing the pricing of Hyalgan (HCPSC code J7315) and Synvis (HCPSC code J7320) to match the dosage within the description of the code. The following pricing and restrictions apply:

HCPSC Code	Description	Maximum Allowable Fee	Restrictions
J7315	Sodium hyaluronate, 20 mg, for intra-articular injection	\$132.20	Maximum of 5 Max. pymt = \$661.00
J7320	Hylan G-F 20, 16 mg, for intra-articular injection	\$215.65	Maximum of 3 Max. pymt = \$646.95

VII. Family Planning

Maximum allowable fees have been established for the following codes:

HCPSC Code	Description	Maximum Allowable Fee
J1055	Depo-Provera Injection, 150 mg	\$40.79
A4261	Cervical Cap	\$46.00
1111J*	Lunelle, Monthly Injection	\$19.96

*State-unique code

VIII. Medical Nutrition Therapy

Retroactive to January 1, 2001 physician's offices that bill for Medical Nutrition Therapy provided by certified dietitians should use the following codes.

These medical nutrition therapy services are allowed only for clients 20 years of age and younger that are referred by an EPSDT provider.

CPT Procedure Code	Short Description	7/1/01 Maximum Allowable Fee
97802	Medical nutrition therapy, individual, initial 1 unit=15 minutes	\$11.49 per unit Max. of 8 units Per year
97803	Medical nutrition therapy, individual, subsequent 1 unit=15 minutes	\$11.49 per unit Max. of 4 units Per day
97804	Medical nutrition therapy, group 1 unit=30 minutes	\$11.49 per unit Max. of 2 units Per day

IX. Coding Changes

- **Dental Anesthesia:** The state-unique code 0100M is discontinued and replaced with the following CPT code:

CPT Code	Short Description	Base Units
00170	Intraoral anesthesia	5

- **Cervical Cancer Screens:** MAA covers HCPCS code **G0101** with the diagnosis **V76.2** only.

X. Coverage Changes

The following procedures are added to those that are covered after prior authorization has been obtained (refer to page A.5 of the Physician Related Services Billing Instructions):

- 61885, 61888, 64573, 64585, 69714, 69715, 69717, 69718, and 69930.

The following procedures no longer require prior authorization:

- 53850 and 53852.

The following HCPCS code is no longer covered, unless an Exception to Rule (ETR) has been obtained (refer to page A.2 of the Physician Related Services Billing Instructions):

- J7330.

XI. Place of Service Code Changes

- Beginning July 1, 2001, providers must bill MAA using **place of service (POS) code 6** for services performed in an **Ambulatory Surgery Center (ASC)**. Providers are reimbursed based on the facility payment for those procedures performed in an ASC.
- Beginning July 1, 2001, providers must bill MAA using **POS code 9** for services performed in a **custodial care facility**. Providers are reimbursed based on the non-facility payment for those procedures performed in custodial care facilities.

Physician-Related Services Billing Instructions

A new edition of the Physician-Related Services Billing Instructions will be mailed out in August 2001. In the meantime, the entire fee schedule can be viewed online at MAA's website at <http://maa.dshs.wa.gov>.

Please bill MAA your usual and customary charge.